

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030288

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7974

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 9 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP. #1</i>		d. STREET ADDRESS (If outside, give location) <i>3965 1/2 OLIVE ST.</i>	
3. NAME OF DECEASED (Type or print) First <i>LEON</i> Middle <i>MILFORD</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>3</i> Year <i>63</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>5/6/1907</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WAITER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HICKMAN, KY.</i>	
13a. FATHER'S NAME <i>JAMES T. MILFORD</i>		13b. MOTHER'S MAIDEN NAME <i>MYRTLE COOPER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <i>NO</i>		17. INFORMANT Address <i>451 LOUISE FELTZ, 9012 KATHLYN</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>& Corated Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Pneumonia</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>331x</i>	
20c. TIME OF INJURY Hour <i>7:15</i> a.m. <i>AM</i> Month, Day, Year <i>7/13/63</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <i>ST. LOUIS, MO.</i>	
21. I attended the deceased from <i>7/13/63</i> to <i>8/3/63</i> and last saw her him alive on <i>8/3/63</i> Death occurred at <i>7:15 AM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. F. Cooper M.D.</i> (Degree or title)		22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>	
22c. DATE SIGNED <i>8/3/63</i>		22d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>8-6-63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR <i>ALBERT H. HOPPE, INC.</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 5 1963</i>	
26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.